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ABSTRACT

The Geriatric Assessment Unit (GAU), which has proven successful in urban areas, may be a viable system for providing health care to the elderly in rural areas. GAUs engage in assessment, follow-up response to findings, education, and research. The assessment component includes, at minimum, physical health, functional ability in activities of daily living, mental health, social circumstances, and financial situation. GAUs ideally include input from a multi-discipline staff, as well as from the older person and from family and/or friends. Evidence from numerous studies shows that rural older people are generally poorer and less physically healthy than their urban counterparts, and their health services are less accessible and less technologically advanced. These facts suggest that geriatric assessment may be particularly important in rural areas. To be successful outside of urban centers, the GAU must take into account the unique attributes and problems of health care systems in rural regions. It will be difficult but essential to recruit a professional staff with special preparation in geriatrics and gerontology. The rural hospital may be the best location for the rural GAU, and the GAU may help to strengthen small hospitals and the rural health system as a whole. (JHZ)

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GERIATRIC ASSESSMENT UNITS AND RURAL HEALTH SYSTEM VIABILITY

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INTRODUCTION

Changes in the composition of the American (and industrialized world) population have led to a situation sometimes characterized as the "geriatric imperative." The proportion of older people is increasing rapidly and poses a major challenge to provision of health care and other services. Several trends are evident (Brody and Persily, 1984):

1. Longer life expectancy for both men and women;
2. Growing numbers of very old people (75 years plus);
3. Smaller families, with less capacity for meeting the health care and other financial needs of older members;
4. Large numbers of older people with one or more chronic illnesses, often accompanied by personal inability to care for all of their needs.

One of approximately every nine people in the United States is presently age 65 or older and the proportion is higher in rural regions. In about 35 years (2020) the proportion is expected to be one of every six.

The elderly are in much greater need of health care than younger members of the population; consequently, they put greater demands on health care resources. The implications for the health care system include, among other considerations, that procedures must be found to improve health care so as to serve needs the needs of older people while minimizing costs (Brody and Persily, 1984). This is among the primary purposes and values of geriatric assessment.

The Geriatric Assessment Unit Concept

The Geriatric Assessment Unit (GAU) is a relatively new phenomenon in the United States, although it has existed in The United Kingdom since the 1930's. Several other countries have developed (or are developing) geriatric care systems modeled to some degree on the British experience. The current U.S. initiative to establish GAU's is among the responses to an obvious need for innovation to better meet the requirements of those who are not well-served by the existing health care system (Rubenstein, 1981).

Although GAU's vary considerably in organization and services offered, they generally include at least four activities: assessment; follow-up response to findings; education; and research. The assessment component usually includes, at minimum: (1) physical health; (2) functional ability in activities of daily living; (3) psychological or mental health; (4) social circumstances; and (5) financial situation.

Generally, GAU's are intended to comprehensively assess these potential problem areas. This serves as a basis for helping determine optimal living arrangements and provides an informed perspective for prevention of further illness, or follow-up therapy and rehabilitation to overcome the consequences of existing conditions (Rubenstein, Rhee, and Kane, 1982).

The ideal result is an overall plan which includes recommendations and activities to restore or preserve functional independence. This helps, among other results, to ensure living arrangements with an appropriate level of care (Barker, 1985).

A major potential of geriatric assessment is demonstration of rehabilitation potential through identification of reversible causes of physical, cognitive and emotional impairment. The assessment procedure can be accompanied by an attempt to correct the distorted and unnecessarily pessimistic view of the possible quality of life for an older individual. Such pessimism is regularly present among physicians, other health care professionals, and among family and friends (Campion, Jette, and Berkman, 1983).

Geriatric Assessment Units ideally include input from a multi-discipline staff, as well as from the older person and, when possible, from family and/or friends. These latter procedures are critical in assessing ability to function in the usual activities of daily living which is just as important as diagnosing specific illnesses. A genuine collaborative effort among participants in an assessment is likely to be most effective in achieving comprehensive understanding and an adequate follow-up program (Michelmore, 1975; Reichel, 1985).

Improved geriatric assessment therefore represents both an opportunity and a challenge--despite the remaining lack of consensus on best procedures or thorough scientific study of outcomes (Rowe, 1985).

Use of tested and relatively easy-to-administer instruments encompassing the major components of geriatric assessment makes the process considerably easier to reliably perform. It also serves as a useful teaching tool for professionals in geratrics and gerontology. This facitiltates communication of clinical information between health care providers, allowing more effective teamwork to occur around meaningful and valid data. The treatment process can more readily be measured over time (Rubenstein, 1983).

The Importance of Follow-up

Follow-up after initial assessment is essential if the results are to be understood and evaluated. Detailed follow-up measurement is crucial, using the techniques similar to the initial assessment. Medical records can provide some of the data but deliberate efforts to institute measurements of change are likely to be valuable. A research posture can be helpful to both older people and the professionals involved in providing services (Kane and Kane, 1985; Barker, 1985; Campion et al, 1983).

RATIONALE FOR A RURAL GERIATRICS ASSESSMENT CAPABILITY

Comprehensive assessment can be the cornerstone of improved elderly health and well-being in rural areas. Advantages are likely to be evident for clinical practitioners, hospitals, nursing homes, outreach services, and other components of service systems, as well as for the elderly.

Without such a careful approach older rural people will remain vulnerable to unnecessary loss of functional capacity arising from the interaction of medical, economic, psychological, and social inadequacies. This often means decreased self-confidence, loss of individual integrity, and increased dependence on family, friends or public assistance (Rowe, 1985; George and Fillenbaum, 1985).

Evidence from numerous studies makes it clear that rural older people are generally more economically disadvantaged and less physically healthy than their urban counterparts. Health services are less accessible and less technologically advanced than in urban centers. This suggests there may be a particularly important potential for development of geriatric assessment capability that fits rural needs (Coward and Lee, 1985; Lassey and Lassey, 1985).

Moreover, because of the current vulnerability of rural health care systems (hospitals especially), and the relatively high proportion of older people in many rural regions, greater attention to the possibilities for strengthening geriatric services may be critical to survival of local rural health care

systems (Rosenblatt and Muscovice, 1982; Muscovice and Rosenblatt, 1985).

Any effort to adequately serve the rural elderly must obviously take into account the unique attributes, and problems of, health care systems in rural regions. Simply attempting to transplant an urban geriatric assessment "model" to rural locations is unlikely to be accepted or successful (Rosenblatt and Muscovice, 1985).

Nonetheless, comprehensive and multidisciplinary assessment in rural situations would seem to be essential if the GAU concept is to provide a significant improvement over the present situation. It will serve no useful purpose to create a new but mediocre capability.

The Needed Professionals

It is unlikely that rural GAU's could employ as wide a range of desirable talent as is possible in the urban setting. Nonetheless the desired multidisplinary apporach requires overlapping knowledge, varied skills, and individuals with appropriate preparation to manage the components. Expert knowledge in the key requirements is essential if the GAU concept is to be an improvement over existing capacities (Martin et al, 1985).

Essential members of the team, each with special preparation in geriatrics and gerontology, include: physicians, nurses, social workers, psychologists, and pharmacologists (Martin,1985).

ALTERNATIVE LOCATIONS FOR RURAL GERIATRIC ASSESSMENT

Urban experience has suggested that GAU's can successfully be located in acute care hospitals, outpatient clinics, long-term care facilities, or medical school teaching hospitals and clinics. Given the limited resources and staff in many rural settings, the hospital appears to be the most viable location--which could contribute to increasing its survival capacity (Rubenstein and Kane, 1985; Muscovice and Rosenblatt, 1985).

Many rural hospitals have the potential for providing most of the needed facilities and some of the staff to serve as part of the basis for outpatient or inpatient assessment; the potential also exists for follow-up treatment and rehabilitation if needed. However, cooperative arrangements between private health care practices, clinics, outreach programs, long-term care units, and a hospital may be both workable and the most efficient use of resources in most rural locations.

An approach to geriatric assessment that is at least in part supported with community tax resources may have the strongest basis for effectiveness in serving the broadest range of older people. However, further experimentation and research is needed before firm conclusions can be drawn that apply to a broad range of rural communities.

THE EDUCATIONAL ROLE OF GERIATRIC ASSESSMENT UNITS

A rural GAU can serve as a focal point for increasing professional knowledge and skills in geriatrics and gerontology. Knowledge is accumulating rapidly. However, channels are needed for information dissemination, particularly in locations away from major medical centers where the information flow may be limited.

Comprehensive geriatric assessment also has the potential for teaching multidisciplinary teamwork--which tends to improve the attitudes of team members towards older people. The variety of disciplines can contribute to the overall well-being of older people. A formal GAU can be an effective means of combining an emphasis on caregiving as well as assessment, while helping to increase empathy with the diverse characteristics and multiple problems encountered in older age (Campion et al, 1983; Besdine, 1983; Crooks et al, 1982).

THE NEED FOR CONTINUED RESEARCH

Much remains to be learned about geriatrics and appropriate assessment in both urban and rural areas. The current information is heavily based on individual cases and cross-sectional studies. Controlled longitudinal studies are needed to clarify what forms of organization and content are appropriate to effective assessement, treatment, and rehabilitation programs. Multidisciplinary research may be particularly crucial in helping to account for the diversity of factors involved (Zimmer, 1985).

POTENTIAL OUTCOMES

Experience with GAUs is not sufficiently conclusive to be as confident as we might like about outcomes, especially with rural populations. However, results from largely urban studies suggest the following advantages should be a minimal expectation (Barker et al, 1985; Rubenstein, 1981; Rubenstein and Kane, 1985; Rubenstein, 1983; Rubenstein et al, 1984):

1. Reduction of mortality by at least one year;
2. Substantially decreased likelihood of residence in nursing homes;
3. Decreased average number of days in a nursing home for those who enter;
4. Decreased likelihood of hospitalization and a higher rate of inpatient discharge;
5. Improved functional status (identifying a relatively small problem that is subject to remedy can lead to remarkable improvement in functional status);
6. Improved morale among individuals assessed;
7. Increased diagnostic accuracy;
8. More appropriate and satisfying home environments;
9. More appropriate use of medication;
10. Better coordination of community support systems;
11. Improved emotional status and sense of well-being;
12. Improved patient management;
13. Increased use of physical therapy, occupational therapy, speech therapy, and other rehabilitative services;
14. Improved quality of life for the older person;

15. Lowered overall cost for the older person and society, because of increased functional independence, decreased use of drugs, and lower morbidity.

Research findings also suggest positive outcomes for health care providers and other professionals in aging (Besdine, 1983; Campion et al, 1983):

16. Promotion of geriatrics education and specialization;

17. Learning about effective multidisciplinary teamwork;

18. Improved awareness of functional problems of older people;

19. Lower populations of older people requiring care in high cost hospitals as well as lower cost nursing homes;

20. Generally greater effectiveness in teaching geriatric care and gerontology to professionals in aging.

These are impressive findings. They suggest that a very large number of older people in rural and urban settings presently residing in hospitals or nursing homes might be able, instead, to live in their own homes with some modest and relatively less expensive level of assistance. The National Center For Health Statistics reported in 1982 that ten million individuals over 65 were discharged from hospitals, of whom 8% went to nursing homes. Geriatric assessment units may have the potential, based on experience to date, of reducing that proportion by half, meaning a reduction by 200,000 in nursing home admissions per year (Rubenstein et al, 1984).

CONCLUDING COMMENTS

We have been involved with the planning and initiation of a geriatric assessment unit in an acute care hospital in Spokane, Washington (Spokane is the regional service and medical center for Eastern Washington, Northern Idaho, and Western Montana). Future plans include initiation of experimental rural GAU's in several communities in the region, using the general concepts discussed here, and with initial co-sponsorship by the Coalition for Rural Health--an advocacy and program development organization sponsored by several universities and other groups with rural health interests.

Our experience and preliminary research suggest that the concepts described earlier in this paper, and in more detail elsewhere (Lassey and Lassey, 1985b), hold considerable potential for implementation of the rural GAU, while also potentially helping to strengthen small hospitals and the larger rural health system. However, because there appear to be no existing well-developed rural "models" we have found it necessary to focus initially on educating rural health professionals and community leaders about the GAU concept.

Future plans also include a strong focus on collaborative program implementation and research by urban and rural professionals. At this juncture it seems unlikely that sufficient understanding and resources can be developed in rural communities without support from outside resources. Of equal importance is the problem of inadequate understanding among urban

professionals of how to successfully initiate a GAU program that effectively serves rural communities. There is strong (although not universal!) agreement that a collaborative approach makes the most sense even though achieving the necessary commitments is difficult to manage.

Hopefully, at some time in the not too distant future we shall be able to report on programatic and research results from these initial efforts. In the meantime we will certainly welcome any information on experience in other rural regions.

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